Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. **Waiver Services Summary.** *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service		
Statutory Service	Adult Day Care		
Statutory Service	Community Day Services		
Statutory Service	Residential Habilitation		
Extended State Plan Service	Occupational Therapy (Extended Medicaid State Plan)		
Extended State Plan Service	Physical Therapy (Extended Medicaid State Plan)		
Extended State Plan Service	Speech Therapy (Extended Medicaid State Plan)		
Supports for Participant Direction	Information and Assistance in Support of Participant Direction		
Other Service	24-Hour Stabilization Services		
Other Service	Adaptive Equipment		
Other Service	Behavior Intervention and Treatment		
Other Service	Behavioral Services (Psychotherapy and Counseling)		
Other Service	Emergency Home Response Services (EHRS)		
Other Service	Home Accessibility Modifications		
Other Service	Non-Medical Transportation		
Other Service	Personal Support		
Other Service	Skilled Nursing		
Other Service	Supported Employment - Individual Employment Support		
Other Service	Supported Employment – Small Group Supports		
Other Service	Temporary Assistance		
Other Service	Training and Counseling Services for Unpaid Caregivers		
Other Service	Vehicle Modification		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Care

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Services generally furnished four or more hours per day on a regularly scheduled basis, for one or more days per week, or as specified in the person centered plan, in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the participant. Meals provided as part of these services shall not constitute a "full nutritional regimen" (three meals per day).

Transportation between the participant's place of residence and the Adult Day Care center will be provided as a component of Adult Day Care (ADC) services. The cost of this transportation is included in the rate paid to providers of ADC services.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Adult Day Care is typically available to participants who are aged 60 and older. Participants who are not yet 60 may also be served if day habilitation or employment services are determined by the person centered planning team not to be appropriate because the participant is medically fragile.

For participants who choose participant-directed supports, this service is included in the participant's monthly cost maximum. See Appendix C-4. Services are subject to prior approval by the Operating Agency.

The annual rate is spread over a State fiscal year maximum of 1,100 hours for any combination of day programs. Payment during any month is limited to a maximum of 115 hours for any combination of day programs.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community-Based Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Adult Day Care

Provider Category:
Agency

Provider Type:
Community-Based Agencies

Provider Qualifications

License *(specify)*:
89 Ill. Adm. Code 240

Certificate *(specify)*:

Other Standard *(specify)*:
59 Ill. Adm. Code 120
Contract with Department on Aging

Verification of Provider Qualifications

Entity Responsible for Verification:
Department on Aging and Waiver Operating Agency

Department on Aging - Surveys are conducted once per contracting period (six years), with additional surveys conducted as necessary due to complaints or deficiencies.

Waiver Operating Agency (DHS) - Verification of contract with the Department on Aging upon enrollment and annually thereafter.

Frequency of Verification:
Department on Aging surveys are conducted once per contracting period (six years), with additional surveys conducted as necessary due to complaints or deficiencies. The OA verifies a contract with the Department on Aging upon enrollment and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Statutory Service

Service:
Day Habilitation

Alternate Service Title (if any):
Community Day Services

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Community Day Services (CDS) assists the with acquisition, retention, or improvement in self-help, socialization and adaptive skills that takes place in a non-residential setting, separate from the participant's private residence or other residential living arrangement. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. Services are furnished four or more hours per day on a regularly scheduled basis for one or more days per week or as specified in the participants person centered plan. Meals provided as part of these services shall not constitute a "full nutritional regimen" (three meals per day).

CDS focus on enabling the participant to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies in the person centered plan. In addition, CDS may serve to reinforce skills or lessons taught in other settings.

CDS also includes a range of adaptive skills in the areas of motor development, attention span, safety, problem solving, quantitative skills, and capacity for individual living. It also enhances a participant's ability to engage in productive work activities through a focus on such habilitative goals as compliance, attendance, and task completion. CDS may also include training and supports designed to maintain skills and functioning and to prevent or slow regression.

CDS developmental supports includes the reduction of maladaptive behaviors through positive behavioral supports and other methods.

CDS does not include the following:
-Special education and related services (as defined in Section 601 (16) and (17) of the Individuals with Disabilities Education Act) which otherwise are available to the participant through a local education agency:
-Vocational rehabilitation services which otherwise are available to the participant through a program funded under Section 110 of the Rehabilitation Act of 1973.

CDS programs include purposeful and meaningful activities that are designed to improve, maintain, or prevent the loss of independence, skills and functions enabling each participant to access and participate in relationships, activities and functions of community life. Activities may consist of job exploration activities (not paid employment) or volunteer work, recreation, educational experiences in natural community settings, maintaining family contacts and purposeful activities and services where persons without disabilities are present.

CDS includes transportation between the residence and other community locations where Site-Based Developmental Supports occurs. Transportation is provided and billed as an integral part of CDS. The cost of transportation is included in the rate paid to providers of CDS. Training and assistance in transportation is provided as needed.

CDS coordinates and provides supports for valued and active participation in integrated weekday activities that build on the person's interests, preferences, gifts, and strengths while reflecting the person's goals with regard to community involvement and membership.

CDS is designed to promote maximum participation in integrated community life while facilitating meaningful relationships, friendships and social networks with persons without disabilities who share similar interests and

goals for community involvement and participation.

CDS shall support and enhance, rather than supplant, an individual's involvement in public education, post-secondary education/training, individualized integrated employment or self-employment, and services designed to lead to these types of employment.

For working-age individuals receiving CDS who are not also working in individualized integrated employment or self-employment, this service includes, and can be exclusively focused on, opportunities for exploration, learning and skill development focused on encouraging pursuit of, and aptitudes for, individualized integrated employment or self-employment.

For individuals receiving CDS that are also working in individualized integrated employment or self-employment, this service includes, and can be exclusively focused on, opportunities for learning and skill development focused on maintaining and expanding aptitudes for continued success in individualized integrated employment or self-employment.

For people who are aging, CDS provides supports for integrated age-appropriate activities.

CDS may provide assistance for active and positive participation in a broad range of integrated community settings that allow the person to engage with people who do not have disabilities who are not paid support staff. The service is expected to result in the person developing and sustaining a range of valued, age-appropriate social roles and relationships; building natural supports; increasing independence; and experiencing meaningful community integration and inclusion. Activities are expected to increase the individual's opportunity to build connections within his/her local community and include (but are not limited to) the following:
o Supports to participate in age-appropriate community activities, groups, associations or clubs to develop social networks;
o Supports to participate in community opportunities related to the development of hobbies or leisure/cultural interests or to promote personal health and wellness (e.g. yoga class, walking group, etc.);
o Supports to participate in adult education and postsecondary education classes;
o Supports to participate in formal/informal associations or community/neighborhood groups;
o Supports to participate in volunteer opportunities;
o Supports to participate in opportunities focused on training and education for self-determination and self-advocacy;
o Supports for learning to navigate the local community, including learning to use public transportation and/or private transportation available in the local area;
o Supports to maintain relationships with members of the broader community (e.g. neighbors, co-workers and other community members who do not have disabilities and who are not paid or unpaid caregivers) through natural opportunities and invitations that may occur.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Documentation is maintained that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
1) Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or
2) Payments that are passed through to users of supported employment services.

For participants who choose participant-directed supports, this service is included in the participant's monthly cost limit. See Appendix C-4.

The annual rate is spread over a State fiscal year maximum of 1,100 hours for any combination of day programs. Monthly payment is limited to a maximum of 115 hours for any combination of day programs.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community-Based Agencies
Agency	Special Recreation Associations

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Community Day Services

Provider Category:
Agency
Provider Type:
Community-Based Agencies
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:
59 Ill. Adm. Code 119 (Developmental Training)
Other Standard *(specify)*:
59 Ill. Adm. Code 50
59 Ill. Adm. Code 120
The Provider must have a current contract with the Operating Agency (OA) and meet all contractual requirements.

Verification of Provider Qualifications
Entity Responsible for Verification:
Waiver Operating Agency (OA)
Frequency of Verification:
Annual certification survey

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Community Day Services

Provider Category:
Agency
Provider Type:
Special Recreation Associations
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:
59 Ill. Adm. Code 119 (Developmental Training)
Other Standard *(specify)*:

59 Ill. Adm. Code 50
59 Ill. Adm. Code 120
The Provider must have a current contract with the Operating Agency (OA) and meet all contractual requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:
Waiver Operating Agency (DHS)
Frequency of Verification:
Annual certification survey

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Statutory Service

Service:
Residential Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope)*:
Residential Habilitation means individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include case management, adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult

educational supports, social and leisure skill development, that assist the participant to reside in the most integrated setting appropriate to his/her needs.

Residential Habilitation also includes personal care and protective oversight and supervision. Payment is not made for the cost of room and board. Included in the cost not covered are building maintenance, upkeep and improvement (other than such costs for modification or adaptations to a facility required to assure the health and safety of residents, or to meet the requirements of the applicable life safety code). Residential Habilitation includes the reduction of maladaptive behaviors through positive behavioral supports and other methods. Payment is not made, directly or indirectly, to members of the participant's immediate family. Transportation provided as a component part of Residential Habilitation is included in the rate paid to providers of Residential Habilitation services.

In addition, Residential Habilitation may include necessary nursing assessment, direction and monitoring by a registered professional nurse, and support services and assistance by a registered professional nurse or a licensed practical nurse to ensure the participant's health and welfare. It also includes administration and/or oversight of the administration of medications consistent with the Illinois Nursing and Advanced Practice Nursing Act (225 ILSC 65) and the Mental Health and Developmental Disabilities Administrative Act. Nursing services are considered an integral part of Residential Habilitation services. Meeting the routine nursing needs of participants receiving 24-hour residential services is the responsibility of the residential service provider who must employ or contract with a professional nurse to perform their professional duties including the oversight and training of direct support staff. Nursing supports are part-time and limited; 24-hour nursing supports, similar to those provided in a nursing facility (NF) or Intermediate Care Facility for individuals with Developmental Disabilities (ICF/IID), are not available to participants in the Waiver. These services are in addition to any Medicaid State Plan nursing services for which the participant may qualify.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Residential Habilitation services are available to participants who require this intensity of service based on their identified needs. Factors involved in the assessment of the need for this service include the urgency of the situation (e.g., the unexpected loss of a caregiver) and the individual's health and welfare concerns (e.g., an abusive or neglectful situation). To ensure criteria are fairly applied to all initial applicants and to those whose circumstances may change once they are enrolled in the Waiver, the Operating Agency staff convene an internal committee to review each request from a statewide perspective.

Residential Habilitation sites are limited in size, depending on the licensure standards for the setting. Community Individual Living Arrangements (CILA) are limited in size to no more than 8 individuals. Community Living Facilities (CLF) are limited to no more than 16 individuals.

This service will not be duplicative of other services in the Waiver. For example, non-medical transportation is an integral component of Residential Habilitation services.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community-Based Agencies (CILA)
Agency	Community-Based agencies (CLF)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:
Agency
Provider Type:
Community-Based Agencies (CILA)
Provider Qualifications
License *(specify)*:
59 Ill. Adm. Code 115 (Community Integrated Living Arrangements - CILA)
Certificate *(specify)*:

Other Standard *(specify)*:
59 Ill. Adm. Code 50
59 Ill. Adm. Code 120
59 Ill. Adm. Code 116
The Provider must have a current contract with the Operating Agency (OA) and meet all contractual requirements
Verification of Provider Qualifications
Entity Responsible for Verification:
Waiver Operating Agency (OA)
Frequency of Verification:
Full licensure surveys are conducted at least every three years, with focused surveys conducted more frequently if serious deficiencies are identified.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:
Agency
Provider Type:
Community-Based agencies (CLF)
Provider Qualifications
License *(specify)*:
77 Ill. Adm. Code 370 (Community Living Facilities - CLF)
Certificate *(specify)*:

Other Standard *(specify)*:
59 Ill. Adm. Code 120
59 Ill. Adm. Code 116

The Provider must have a current contract with the Operating Agency (OA) and meet all contractual requirements.
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Public Health
Frequency of Verification:
Annual surveys and ongoing complaint investigations

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Occupational Therapy (Extended Medicaid State Plan)

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope)*:

Occupational Therapy services under the waiver differ in nature and scope from Occupational Therapy services in the Medicaid State Plan. Waiver Occupational Therapy focuses on the long-term therapeutic needs of the participant, rather than short-term acute restorative needs. Restorative services are covered under the Medicaid State Plan. This waiver service is only provided to individuals age 21 and over. All medically necessary Occupational Therapy services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

For participants who choose participant-directed supports, this service is included in the participant's monthly cost limit. See Appendix C-4.

There is a State fiscal year maximum of 26 hours, unless additional documentation supports the need for additional hours (up to 52 hours).

Services are subject to prior approval by the Operating Agency.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Occupational Therapist

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Occupational Therapy (Extended Medicaid State Plan)

Provider Category:
Individual

Provider Type:
Occupational Therapist

Provider Qualifications

License *(specify)*:
225 ILCS 75/1 et seq.
68 Ill. Adm. Code 1315

Certificate *(specify)*:

Other Standard *(specify)*:
Occupational Therapist may directly supervise a Certified Occupational Therapist Assistant

Verification of Provider Qualifications

Entity Responsible for Verification:
Waiver Operating Agency and Medicaid Agency

Frequency of Verification:
The Operating Agency (OA) verifies upon enrollment, and the Medicaid Agency (MA) conducts a monthly verification of continuation of licensure.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Extended State Plan Service

Service Title:
Physical Therapy (Extended Medicaid State Plan)

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope)*:
Physical Therapy services under the waiver differ in nature and scope from Physical Therapy services in the Medicaid State Plan. Waiver Physical Therapy focuses on the long-term therapeutic needs of the participant, rather than short-term acute restorative needs. Restorative services are covered under the Medicaid State Plan. This waiver service is only provided to individuals age 21 and over. All medically necessary Physical Therapy services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
For participants who choose participant-directed supports, this service is included in the participant's monthly cost limit. See Appendix C-4.

There is a State fiscal year maximum of 26 hours, unless additional documentation supports the need for additional hours (up to 52 hours).

Services are subject to prior approval by the Operating Agency.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Physical Therapist

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service

Service Name: Physical Therapy (Extended Medicaid State Plan)

Provider Category:
Individual

Provider Type:
Physical Therapist

Provider Qualifications

License *(specify)*:
225 ILCS 90/1 et seq.
68 Ill. Adm. Code 1340

Certificate *(specify)*:

Other Standard *(specify)*:
Physical Therapist may directly supervise a certified Physical Therapy Assistant.

Verification of Provider Qualifications

Entity Responsible for Verification:
Operating Agency (OA) and Medicaid Agency (MA)

Frequency of Verification:
The Operating Agency verifies upon enrollment and the Medicaid Agency conducts a monthly verification of continuation of licensure.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Extended State Plan Service

Service Title:
Speech Therapy (Extended Medicaid State Plan)

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

Service is included in approved waiver. There is no change in service specifications.

- [ ] **Service is included in approved waiver. The service specifications have been modified.**
- [ ] **Service is not included in the approved waiver.**

Service Definition *(Scope)*:
Speech Therapy services under the waiver differ in nature and scope from Speech Therapy services in the Medicaid State Plan. Waiver Speech Therapy focuses on the long-term therapeutic needs of the participant, rather than short-term acute restorative needs. Restorative services are covered under the Medicaid State Plan. This waiver service is only provided to individuals age 21 and over. All medically necessary Speech Therapy services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
For participants who choose participant-directed supports, this service is included in the participant's monthly cost limit. See Appendix C-4.

There is a State fiscal year maximum of 26 hours, unless additional documentation supports the need for additional hours (up to 52 hours).

Services are subject to prior approval by the Operating Agency.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Speech/Language Pathologist

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Speech Therapy (Extended Medicaid State Plan)

Provider Category:
Individual
Provider Type:
Speech/Language Pathologist
Provider Qualifications
License *(specify)*:
225 ILCS 110/1 et seq.
68 Ill. Adm. Code 1465
Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications
Entity Responsible for Verification:

Operating Agency (OA)and Medicaid Agency (MA)
Frequency of Verification:
The Operating Agency (OA) verifies upon enrollment and the Medicaid Agency (MA) conducts a monthly verification of continuation of licensure.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Supports for Participant Direction
The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.
Support for Participant Direction:
Information and Assistance in Support of Participant Direction
Alternate Service Title (if any):

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

Service Definition *(Scope)*:
Information and Assistance in Support of Participant Direction assists the participant (or the participant's family or representative, as appropriate) in arranging for, directing and managing services. Practical skills training is offered to enable families and participants to independently direct and manage waiver services. Examples of skills training include providing information on recruiting and hiring personal support workers, managing workers, and providing information on effective communication and problem-solving. The service/function includes providing information to ensure that participants understand the responsibilities involved with directing

their services. The extent of the assistance furnished to the participant or family is specified in the Person Centered Plan.

ISC agencies may not employ persons who may also provide this waiver service or other waiver services to participants.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
This service is included in the participant's annual cost maximum, see Appendix C-4. There is no specific service maximum.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community-based agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction
Service Name: Information and Assistance in Support of Participant Direction

Provider Category:
Agency

Provider Type:
Community-based agencies

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Entity under contract with the Operating Agency that does not also provide Individual Service and Support Advocacy. Services must be provided personally by a professional defined in federal regulations as a Qualified Intellectual Disabilities Professional.

ISC agencies may not employ persons who may also provide this waiver service or other waiver services to participants.

Verification of Provider Qualifications

Entity Responsible for Verification:
Waiver Operating Agency (DHS)

Frequency of Verification:
Upon enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

24-Hour Stabilization Services

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope)*:

24-Hour Stabilization Services are designed to meet the needs of participants who require short-term, temporary services outside of their existing homes. The service is directed at individuals who are experiencing acute behavioral conditions that result in difficulties in stabilization in the individuals' existing habilitation setting. Stabilization functions may include but are not limited to development of a sustainable behavior plan and interventions, implementation of positive and necessary behavior interventions, monitoring and tracking of individuals' behaviors, remediation of negative peer to peer interactions, resolution of other issues that are jeopardizing the individual's current service delivery, technical assistance to habilitation service providers serving the participant, and follow-up review on individual progress and phone consultation regarding remediation of identified issues.

24-Hour Stabilization Services providers must ensure that direct support staff working in the settings receives the basic direct support staff training that is required of all direct support staff in the Waiver plus an additional 20 hours of training targeting the unique needs of participants who seek the 24-Hour Stabilization Service. 24-Hour Stabilization Service providers will be required to submit their curriculum and show documentation of staff completion of this additional 20 hours of training. In addition, providers must document the credentials and experience of the trainer or trainers proposed by the provider and this documentation must be approved in advance by the Operating Agency.

The Operating Agency requires that the training is focused on initial and on-going safety and well-being of the individual (and other individuals and staff in the 24-Hour Stabilization Services homes) and specific program and behavioral needs of the individual to facilitate the individual's return to his or her previous setting or an appropriate alternative. Training topics for direct support staff include, but are not limited to:
• Welcome of the individual into the new temporary home
• Introduction of the individual to other individuals in the temporary home
• Building rapport/developing relationships with a strong positive philosophy of purpose and goals of the service encouraging safety, security, revised/modified plans of care and understanding of the participant's return to their previous residential setting
• Signs and symptoms of medication toxicity or non-therapeutic medication levels
• Recognizing, describing (verbally and in writing) and addressing escalating behavior
• Tension reduction and behavior de-escalation strategies using non-violent crisis management and intervention techniques that include how to deal with agitation, aggressiveness, crisis de-escalation
• Restraint techniques, if necessary (inclusive of physical, mechanical and chemical restraint) and nonphysical and verbal strategies for the prevention and risk reduction of crisis and other potential incidences of injurious situations
• Organizing meaningful structure of the day, evening and night, again with an emphasis on a strong positive philosophy of purpose and goals of the service directed at implementing a continuation of implemented strategies in the plan of care that follows the individual upon his/her return to the previous setting
• Aiding in return by the individual to the structure of the day, evening or night after escalation of behavior/de-escalation of behavior
• Aiding in return of the individual to his previous home or an appropriate alternative

This enhanced training with a curriculum and trainers approved by the Operating Agency is required in advance of service delivery in the 24-Hour Stabilization Services settings. Refresher training is required by the Operating Agency at least every two years after initial training inclusive of training topics which may be identified through the provider's program operations and provider or Operating Agency quality assurance activities.
The role of QIDPs requires active involvement with direct support staff including intensive data tracking and reporting, behavior modeling, team leadership, and post service progress. The individual QIDP ratio is 1 to 4.

Behavior therapy consultation is provided by Board-Certified Behavior Analysts as part of this service. This consultation includes such activities as training provider staff and family members/guardians in individualized behavioral analysis concepts, crisis intervention including formal recommendations of strategies and responses, demonstrating and modeling individualized techniques, educating staff regarding best practice methods as they may be relevant to specific individuals, developing individual-specific data collection and reporting systems, and monitoring individual service implementation and outcomes. Behavior plans are written by Board-Certified Behavior Analysts with consultation and coordination from the QIDPs. Each behavior plan developed will augment the existing behavior plan where appropriate and will address individuals' respective needs.

Providers must include nursing oversight, mental health expertise, when needed, coordination of ancillary services as part of this service, and ongoing dialogue and planning with other service providers for the participant to ensure a successful return to the former residential setting.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The services are temporary and short-term in nature. An individual will typically receive no more than 90 consecutive days of 24-Hour Stabilization Services, but may be approved for additional days by the Operating Agency. The initial goal of the Operating Agency is that these temporary services would last on average no more than 30 consecutive days per participant. 24-Hour Stabilization Services require prior approval by the Operating Agency.

The Operating Agency will establish and maintain four homes statewide for this service provision. Each home will have four single bedrooms.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Community Integrated Living Arrangement (CILA) agency under contract to provide 24-Hour Stabilization services.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: 24-Hour Stabilization Services

Provider Category:
Agency

Provider Type:
Licensed Community Integrated Living Arrangement (CILA) agency under contract to provide 24-Hour Stabilization services.

Provider Qualifications

License *(specify)*:
CILA which must have a current license under ILCS 59:115.

Certificate *(specify)*:

Other Standard *(specify)*:
1) Must have a contract with the Operating Agency.
2) Providers will be selected through a Request For Applications process. No more than two providers will be selected.
3) The providers' homes must be accessible.

Verification of Provider Qualifications

Entity Responsible for Verification:
The Operating Agency (DHS) is responsible for verification of provider qualifications upon enrollment and on an ongoing basis.

Frequency of Verification:
The Operating Agency (DHS) verifies provider qualifications upon enrollment and on an ongoing basis

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Adaptive Equipment

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Adaptive Equipment, as specified in the Person Centered Plan, includes (a) devices, controls, or appliances that enable participants to increase their ability to perform activities of daily living; (b) devices, controls or appliances that enable participants to perceive, control, access or communicate within the environment in which they live; and (c) such other durable equipment not available under the State Plan that is necessary to address participant functional limitations. The cost of the service may include training or technical assistance for the participant.

Assistive Technology is a device, item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants. Assistive Technology service is a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device. Assistive Technology includes:
1. The evaluation of the Assistive Technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate Assistive Technology and appropriate services to the participant in the customary environment of the participant.
2. Services consisting of purchasing, leasing, or otherwise providing for the acquisition of Assistive Technology devices for participants.
3. Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing Assistive Technology devices.
4. Coordination and use of necessary therapies, interventions, or services with Assistive Technology devices, such as therapies, interventions, or services associated with other services in the person centered plan.
5. Training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant in the operation and/or maintenance of the AT device.
6. Training or technical assistance for professionals or other persons who provide services to, employ, or are otherwise substantially involved in the major life functions of participants in the operation and/or maintenance of the AT device.

Items reimbursed with Waiver funds do not include any medical equipment and supplies furnished under the State Plan and exclude those items that are not of direct remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation. All purchased items shall be the property of the participant or the participant's family.

The cost of the service may include training the participant or caregivers in the operation and/or maintenance of

the equipment.

The cost of the service may include the assessment of the adaptive functioning needs of the participant and the indentification of the type of equipment needed by the participant.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
For participants who choose home-based, this service is not included in the participant's monthly cost limit.

There is a $15,000 maximum per participant per five-year period for any combination of Adaptive Equipment, Assistive Technology, Home Modifications and Vehicle Modifications. See Appendix C-4.

This service is subject to prior approval by the Operating Agency.

Items reimbursed with Waiver funds do not include any Assistive Technology or Adaptive Equipment furnished by the school program or by the Medicaid State Plan and exclude those items that are not of direct remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation. All purchased items shall be the property of the participant or the participant's family.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Equipment Vendors

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adaptive Equipment

Provider Category:
Agency
Provider Type:
Equipment Vendors
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Enrolled vendors approved by the participant or guardian, if one has been appointed.
Verification of Provider Qualifications
Entity Responsible for Verification:
Waiver Operating Agency (OA)
Frequency of Verification:
Upon enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Behavior Intervention and Treatment

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ● **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope)*:

Behavior Intervention and Treatment includes a variety of individualized, behaviorally-based treatment models consistent with best practice and research on effectiveness that are directly related to the participant's therapeutic goals. Interventions include, but are not limited to: Applied Behavior Analysis, Relationship Development Intervention (RDI), and Floor Time. These services are designed to assist participants to develop or enhance skills with social value, lessen behavioral excesses and improve communication skills. Key elements are:

• Approach is tailored to address the specific behavioral needs of the participant;
• Targeted skills are broken down into small attainable tasks;
• Direct support staff and informal caregiver training is a key component so that skills can be generalized and communication promoted;
• Services must be directly related to the participant's therapeutic goals contained in the person centered plan; and
• Success is closely monitored with detailed data collection.

A behavior consultant assesses the participant, including analysis of the presenting behavior and its antecedents and consequences, and develops written behavior strategies based upon the participant's individual needs. The

strategies are a component of the person centered plan and must be approved by the participant, guardian if one has been appointed, Independent Service Coordination (ISC) agency and the other members of the planning team. The behavior consultant monitors progress on at least a monthly basis and more frequently if needed to address issues with the participant's outcomes. A progress report is prepared by the behavior consultant and sent to the person centered planning team at least every six months. This progress report is available to State staff upon request to evaluate the efficacy of the intervention and treatment.

The behavior consultant supervises implementation of the behavior strategy. This includes training of the direct support staff and unpaid informal caregivers to ensure that they apply the interventions properly, understand the specific services and outcomes for the participant being served, and know the procedures for regularly reporting participant progress.

Services are provided by professionals working closely with the participant's direct support staff and unpaid informal caregivers in the participant's home and other natural environments. Direct support staff and unpaid informal caregivers of participants receiving Behavior Intervention and Treatment are vital members of the behavior team. They must be involved in the initial training session to initiate services, and must remain involved with the behavior consultant so that they are able to carry through and reinforce the behaviors being worked on.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
For participants who choose participant-directed supports, this service is included in the participant's monthly cost limit. See Appendix C-4.

There is a State fiscal year maximum of 104 hours with additional hours (beyond 104) available with prior approval from the Operating Agency.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Behavior Consultant

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavior Intervention and Treatment

Provider Category:
Individual

Provider Type:
Behavior Consultant

Provider Qualifications

License *(specify)*:
225 ILCS 15/1 et. Seq.
68 Ill. Adm. Code 1400

Certificate *(specify)*:
Board Certified Behavior Analyst (at www.bacb.com)

Other Standard *(specify)*:

1. Licensed clinical psychologist

2. Masters level professional who is certified as a Behavior Analyst by the Behavior Analyst Certification Board (bacb.com)

3. Bachelor's level professional who is certified as an Associate Behavior Analyst by the Behavior Analyst Certification Board (bacb.com)

6. Professional who is certified to provide Relationship Development Assessment. Information is at rdiconnect.com.

7. Professional with a Bachelor's Degree in a human service field and who has completed at least 1,500 hours of training or supervised experience in the application of behaviorally-based therapy models consistent with best practice and research on individuals with Autism Spectrum Disorder.

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver Operating Agency (AO) and the Medicaid Agency (MA)

Frequency of Verification:

Operating Agency (OA) verifies upon enrollment and verifies continuation of national certification (www.bcba).

Medicaid Agency conducts a monthly check for continuation of licensure for clinical psychologists.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Behavioral Services (Psychotherapy and Counseling)

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ● **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope)*:
Psychotherapy is a treatment approach that focuses on a goal of ameliorating or reducing the symptoms of emotional, cognitive or behavioral disorder and promoting positive emotional, cognitive and behavioral development. Counseling is a treatment approach that uses relationship skills to promote the participant's abilities to deal with daily living issues associated with their cognitive or behavioral problems using a variety of supportive and re-educative techniques.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
For participants who choose participant-directed supports, this service is included in the participant's monthly cost limit. See Appendix C-4.

There is a State fiscal year maximum of 60 hours for any combination of psychotherapy and counseling services.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Licensed Psychotherapists
Individual	Licensed Counselors

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavioral Services (Psychotherapy and Counseling)

Provider Category:
Individual
Provider Type:
Licensed Psychotherapists
Provider Qualifications
License *(specify)*:
225 ILCS 15/1 et. Seq.
68 Ill. Adm. Code 1400
225 ILCS 20/1 et seq.
68 Ill. Adm. Code 1470
225 ILCS 55/1 et seq.
68 Ill. Adm. Code 1283
225 ILCS 107/1 et seq.
68 Ill. Adm. Code 1375

Certificate *(specify):*

Other Standard *(specify):*
Clinical Psychologist
Clinical Social Worker
Marriage/Family Therapist
Clinical Professional Counselor

Verification of Provider Qualifications

Entity Responsible for Verification:
Operating Agency (OA) and Medicaid Agency (MA)

Frequency of Verification:
Operating Agency (OA) verifies upon enrollment.

Medicaid Agency conducts a monthly check for continuation of licensure for licensed professionals.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavioral Services (Psychotherapy and Counseling)

Provider Category:
Individual

Provider Type:
Licensed Counselors

Provider Qualifications

License *(specify):*
All licensure categories for psychotherapists, plus:
225 ILCS 20/1 et seq.
68 Ill Adm. Code 1470
225 ILCS 107/1 et seq.
68 Ill. Adm. Code 1375

Certificate *(specify):*

Other Standard *(specify):*
Social Worker
Professional Counselor

Verification of Provider Qualifications

Entity Responsible for Verification:
Operating Agency (OA) and Medicaid Agency (MA)

Frequency of Verification:
Operating Agency verifies upon enrollment.

Medicaid Agency conducts a monthly check for continuation of licensure for licensed professionals.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Emergency Home Response Services (EHRS)

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope)*:

Emergency Home Response Services (EHRS) is defined as a 24-hour emergency communication link to assistance outside the participant's home for individuals based on health and safety needs and mobility limitations. This service is provided by a two-way voice communication system consisting of a base unit and an activation device worn by the participant that will automatically link the individual to a professionally staffed support center. Whenever the system is engaged by a participant, the support center assesses the situation and directs an appropriate response. The purpose of providing EHRS is to improve the independence and safety of participants in their own homes in accordance with the authorized person centered plan, and thereby help reduce the need for institutional care or out-of-home placement in a more restrictive setting.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service will not be duplicative of other services in the waiver. For example, routine supervision and emergency response are an integral component of residential services.

EHRS are limited to participants who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, have no regular companion and who would otherwise require extensive routine supervision.

For participants who choose participant-directed supports, this service is included in the participant's monthly cost limit. See Appendix C-4.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**

☐ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

☐ **Legally Responsible Person**
☐ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified vendor

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Emergency Home Response Services (EHRS)

Provider Category:
Agency
Provider Type:
Certified vendor
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:
Certified by the Department on Aging
Other Standard *(specify)*:
Annual written rate agreements with the Department on Aging and the OA.

Verification of Provider Qualifications
Entity Responsible for Verification:
Department on Aging
Operating Agency (OA)
Frequency of Verification:
Initial Certification and recertification no less frequently than every three years by Department on Aging.

Upon enrollment and annual verification of Department on Aging written rate agreement by OA.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Home Accessibility Modifications

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope)*:
Those physical adaptations to the private residence of the participant or the participant's family, required by the participant's support plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the adaptive equipment that are necessary for the welfare of the participant.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Excluded are those adaptations or improvements to the home that are of general utility, such as carpeting, roof repair, central air conditioning, and are not of direct remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit. Seasonal items such as swimming pools and related equipment are excluded. All services shall be provided in accordance with applicable State or local building codes.

This service is not included in the participant's monthly cost limit/individual budget.

There is a $15,000 maximum per participant per five-year period for any combination of Adaptive Equipment/Assistive Technology, Home and Vehicle Modifications.

Within the five-year maximum, there is also a $5,000 maximum per address for permanent home modifications for rented homes. See Appendix C-4.

This service is subject to prior approval by the Operating Agency.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- [ ] **Legally Responsible Person**

☐ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Construction Companies
Individual	Independent Contractor

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Accessibility Modifications

Provider Category:
Agency
Provider Type:
Construction Companies
Provider Qualifications
License *(specify)*:
Certificate *(specify)*:
Other Standard *(specify)*:
Enrolled vendor approved by the participant or guardian, if one has been appointed.
Verification of Provider Qualifications
Entity Responsible for Verification:
Waiver Operating Agency (OA)
Frequency of Verification:
Upon enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Accessibility Modifications

Provider Category:
Individual
Provider Type:
Independent Contractor
Provider Qualifications
License *(specify)*:
Certificate *(specify)*:
Other Standard *(specify)*:
Enrolled vendor approved by the participant or guardian, if one has been appointed.
Verification of Provider Qualifications
Entity Responsible for Verification:

Waiver Operating Agency (OA)
Frequency of Verification:
Upon enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Non-Medical Transportation

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ● **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope)*:
Non-Medical Transportation is a service offered in order to enable waiver participants to gain access to waiver and other community services, activities and resources, as specified by the person centered plan. This service is offered in addition to medical transportation required under the Code of Federal Regulations (42 CFR §431.53) and transportation services under the Medicaid State Plan, defined in the Code of Federal Regulations at 42 CFR §440.170(a) (if applicable), and does not replace them. Transportation services under the Waiver are offered in accordance with the participants person centered plan. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge are utilized.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Excluded is transportation to and from covered Medicaid State Plan services. Also excluded is transportation to and from day habilitation program services.

For participants who choose participant-directed supports, this service is included in the participant's monthly cost limit.

This service will not be duplicative of other services in the Waiver.

No more than $500 of the participant's monthly cost limit may be used for Non-Medical Transportation services. This limit was established through input from an external advisory committee of family representatives and is based on their opinions of individuals' and families' needs.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Carriers
Agency	Community-based agencies
Agency	Public and private carriers
Agency	Special Recreation Associations

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:
Individual

Provider Type:
Individual Carriers

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Drivers must have appropriate state licenses and proof of insurance

Verification of Provider Qualifications

Entity Responsible for Verification:
Waiver Operating Agency (OA)

Frequency of Verification:
Upon enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:
Agency
Provider Type:
Community-based agencies
Provider Qualifications
License *(specify)*:
Certificate *(specify)*:
Other Standard *(specify)*:
Drivers must have appropriate state licenses and proof of insurance
Verification of Provider Qualifications
Entity Responsible for Verification:
Waiver Operating Agency (OA)
Frequency of Verification:
Upon enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:
Agency
Provider Type:
Public and private carriers
Provider Qualifications
License *(specify)*:
Certificate *(specify)*:
Other Standard *(specify)*:
Must meet existing requirements for public and private carriers
Verification of Provider Qualifications
Entity Responsible for Verification:
Waiver Operating Agency (OA)
Frequency of Verification:
Upon enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:
Agency
Provider Type:
Special Recreation Associations
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Drivers must have appropriate state licenses and proof of insurance
Verification of Provider Qualifications
Entity Responsible for Verification:
Waiver Operating Agency (OA)
Frequency of Verification:
Upon enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Personal Support

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17090 other

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ● **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope)*:
Personal Support services include:

• Teaching adaptive skills to assist the participant to reach personal goals;
• Personal assistance in activities of daily living;
• Services provided on a short-term basis because of the absence, incapacity or need for relief of those persons who normally provide care (typically referred to as respite).

Supports are typically provided in such areas as eating, bathing, dressing, personal hygiene, community integration, meal preparation (excluding the cost of the meals), transportation and other activities of daily living. Supports may be provided to assist the participant to perform such tasks as light housework, laundry, grocery shopping, using the telephone, and medication management, which are essential to the health and welfare of the participant, rather than for the participant's family. Supports may be provided to develop skills in money management or skills necessary to self-advocate, exercise civil rights and exercise control and responsibility over other support services. Such assistance also may include the supervision of participants as provided in the support plan.

Personal Support may function as an extension of behavioral and therapy services. Extension of services means activities by the Personal Support worker that assist the participant to implement a behavioral, occupational therapy, physical therapy, or speech therapy plan to the extent permitted by state law and as prescribed in the Person Centered Plan. Implementation activities include assistance with exercise routines, range of motion, reading the therapist's directions, helping the participant remember and follow the steps of the plan or hands-on assistance. It does not include the actual service the professional therapist provides.

Personal Support is not intended to include professional services, home cleaning services, or other community services used by the general public.

Personal Support may be provided in the participant's home and may include supports necessary to participate in other community activities outside the home.

The need for Personal Support and the scope of the needed services must be documented in the person centered plan.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Personal Support will not be duplicative of other services in the Waiver, i.e., Residential Habilitation, Developmental Training, etc., since the scope of Personal Support services are already included in those services.

This service is included in the participant's monthly cost limit. See Appendix C-4.

For participants still enrolled in secondary education, no Personal Support services may be delivered during the typical school day relative to the age of the participant or during times when educational services are being provided.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☑ **Relative**

☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Personal Support Worker
Agency	Community-Based Agencies and Special Recreation Associations

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Support

Provider Category:
Individual

Provider Type:
Personal Support Worker

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Aged 18 or older, and is deemed by the participant or guardian, if one has been apppointed, to be qualified and competent to meet the participant's needs and carry out responsibilities assigned via the person centered plan.

Workers hired on or after July 1, 2007, must have passed required background checks including criminal background and Health Care Worker Registry checks prior to employment and annually thereafter.

Verification of Provider Qualifications

Entity Responsible for Verification:
Financial Management Service (FMS) entities and Waiver Operating Agency (OA).

Frequency of Verification:
Financial Management Service (FMS) entity verifies upon enrollment and Waiver Operating Agency conducts annual review of a representative sample.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Support

Provider Category:
Agency

Provider Type:
Community-Based Agencies and Special Recreation Associations

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
The provider must have a contract with the Operating Agency (OA). Per contractual requirements, employees must complete Operating Agency-approved direct support personnel training program and pass competency-based training assessments (40 hours of classroom and 80 hours of on-the-job training) and be certified as direct support personnel (DSP).
All employees of the provider must pass required background checks including criminal background and Health Care Worker Registry checks prior to employment and annually thereafter.

Verification of Provider Qualifications

Entity Responsible for Verification:
Waiver Operating Agency (OA)

Frequency of Verification:
OA verifies upon enrollment and conducts an annual review of contract continuation.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Skilled Nursing

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope)*:
Services listed in the person centered plan that are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical nurse under the supervision of a registered nurse, licensed to practice in the State.
These services are in addition to any Medicaid State Plan nursing services for which the participant may qualify.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
This service will not be duplicative of other services in the Waiver. For example, nursing services beyond those covered in the State Plan, are a component of residential services.

For participants who choose participant-directed supports, this service is included in the participant's monthly cost limit. See Appendix C-4.

There is a State fiscal year combined maximum of 365 hours of service by a registered nurse and 365 hours of service by a licensed practical nurse.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Registered Nurse; or Licensed Practical Nurse, under supervision by an RN

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:
Individual
Provider Type:
Registered Nurse; or Licensed Practical Nurse, under supervision by an RN
Provider Qualifications
License *(specify)*:
225 ILCS 65/1 et seq.
68 Ill. Adm. Code 1300
Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency (DHS) and Medicaid Agency (MA)
Frequency of Verification:
The Operating Agency verifies upon enrollment and the Medicaid Agency conducts a monthly check for continuation of licensure for licensed professionals.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Supported Employment - Individual Employment Support

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

Service Definition *(Scope)*:

Supported Employment-Individual Employment Support services are the ongoing supports to participants who, because of their disabilities, need on-going supports to obtain and maintain an individualized integrated employment or self-employment defined as follows:

Individualized Integrated Employment: Sustained paid employment in an individualized, competitive or customized job, in an integrated work setting in the general workforce, for which an individual is compensated at or above the state's minimum wage (or local minimum wage if higher), with the optimal goal being not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. An integrated work setting means a setting typically found in the community in which individuals interact with non-disabled individuals, other than non-disabled individuals who are providing services to those individuals, to the same extent that non-disabled individuals in comparable positions interact with other persons.

Individualized Integrated Self-Employment: Sustained paid self-employment that is home-based or conducted in an integrated setting(s) where pre-tax income, after business expenses are deducted, divided by the

individual's hours worked is equivalent to no less than the state's minimum wage (or local minimum wage if higher), after a reasonable self-employment start-up period. An integrated setting means a setting where individuals without disabilities engaged in the same or a similar type of self-employment typically work, in which individuals interact with non-disabled individuals, other than non-disabled individuals who are providing services to those individuals, to the same extent that non-disabled individuals in comparable types of self-employment interact with other persons.

These services are designed to support the achievement of individualized integrated employment or self-employment outcomes consistent with the individual's employment and career goals.

Supported Employment—Individual Employment Support services are individualized and may include one or more of the following components:
• Job and Career Exploration;
• Discovery/Career Planning;
• Job Development/Customized Job Placement or Self-Employment Start-Up;
• Supports to maintain individualized integrated employment or self-employment including job analysis, on-the-job training and systematic instruction, job coaching including as-needed employer consultation/support, mobility training and support, and other workplace assistance services including services not specifically related to job skill training that enable the waiver participant to be successful in integrating into the job setting; and
• Benefits counselling, planning, analysis and financial literary.

Each of these five components are further defined in State guidelines.

Supported employment individual employment supports may also include support to establish or maintain self-employment, including home-based self-employment. Services for self-employment may include: (a) aiding the participant to identify potential business opportunities (as part of Discovery); (b) assistance in the development of a business plan, including identifying potential sources of business financing and other assistance in developing and launching a business (as product of Career Planning); (c) identification of the supports that are necessary in order for the participant to operate the business (as part of Self-Employment Start-Up); and (d) ongoing assistance, counseling and guidance once the business has been launched (as part of Supports to Maintain Integrated Self-Employment). Waiver funds may not be used to defray expenses associated with starting up or operating a self-employment business.

When services are funded to enable a participant to obtain individualized integrated employment, the expected outcome that the individual makes an informed choice as to his or her employer of record.

In situations where the provider of Supported Employment -Individual Employment Support services wishes to hire a participant, to work for an organization or entity the provider owns or operates, in a job that meets the definition of individualized integrated employment, the provider shall maintain a policy, and inform individuals receiving the service of the policy, that gives a participant the option to identify a separate provider of Supported Employment-Individual Employment Support services that can provide the on-going supports the person needs to maintain the job, if a situation arises where the participant wishes to change provider for any reason. This will preserve the Medicaid free-choice-of-provider requirement while not discouraging providers from hiring waiver participants in individualized integrated employment situations.

Supported Employment – Individual Employment Support services include transportation. Transportation of the individual to and from these services is included in the rates paid for these services, if needed by individuals participating in these services; however, face-to-face time spent transporting an individual to and from these services is not considered billable time. Transportation during the provision of these services is also included in the rates paid for these services.

A provider of Supported Employment-Individual Employment Support services may also receive Social Security's Ticket to Work Outcome and Milestone payments. These payments do not conflict with CMS regulatory requirements and do not constitute an overpayment of Federal dollars for services provided.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Supported Employment—Individual Employment Support does not include payment for supervision, training, support and adaptations typically available to other non-disabled workers filling similar positions in the business.

Supported Employment—Individual Employment Support does not include supports for volunteering, but may be used to support participation in vocationally-focused internships. Internships are distinguished from volunteering in that:
• Volunteering never occurs in for-profit businesses or organizations that do not have charitable status;
• Internships are focused on developing specific work skills while volunteering is focused on developing general non-job-specific skills for employment and/or charitable contribution;
• Internships should lead to individualized integrated employment or self-employment after a reasonable period of time, while volunteering may continue indefinitely if the goal is charitable contribution.
If internships are unpaid, all federal labor laws must be followed. Internships that are paid must be paid at minimum wage or higher; however, waiver funding cannot be used to pay wages to participants for internships or employment.

The Supported Employment—Individual Employment Support provider shall be responsible for any personal assistance needs during the time that Supported Employment-Individual Employment Support services are provided; however, personal assistance services may not comprise the entirety of the Supported Employment—Individual Employment Support service(s) being provided to an individual.

This waiver will not cover Supported Employment-Individual Employment Support services which are otherwise available to the individual under section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.). Documentation is maintained that the specific type(s) of Supported Employment-Individual Employment Support services being provided is not immediately available, or available without undue delay, to the individual under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

This service may be combined with services being provided to the individual under section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.), so long as this service is not duplicative of what is being provided to the individual under section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.).

An individual's person-centered support plan may include more than one non-residential habilitation service (Supported Employment-Individual, Supported Employment-Small Group, Community Day Services); however, they may not be billed for during the same period of time (e.g., the same 15 minute or hour unit of time).

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
o Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment;
o Payments that are passed through to users of supported employment services; or
o Payments for training that is not directly related to an individual's supported employment program.

These services do not include supporting paid employment or training in a sheltered workshop or similar facility-based setting.

The annual rate is spread over a State fiscal year maximum of 1,100 hours for any combination of day programs. Payment during any month is limited to a maximum of 115 hours for any combination of day programs.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community-Based Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Supported Employment - Individual Employment Support

Provider Category:
Agency
Provider Type:
Community-Based Agencies
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
• Job Coach Qualifications:
o High School Diploma or GED
o Pass registry and background check(s) required by the OA
o Complete all staff training requirements as specified in OA guidelines
o Successfully complete Job Coach certification within 6 months of hire
Successfully complete "TRN Job Coaching and Consulting on-demand" on-line competency-based training: http://trn-store.com/catalog/job-coaching-and-consulting
Complete 40 hours of job shadowing with Supported Employment – Individual Employment Supports in at least three different employment situations
o Valid driver's license if providing service in area where this is necessary.
o Automobile liability insurance if DSP will be transporting waiver participants in his/her own vehicle.

Verification of Provider Qualifications
Entity Responsible for Verification:
Waiver Operating Agency (OA)
Frequency of Verification:
The OA verifies upon enrollment and conducts an annual review of contract continuation.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Supported Employment – Small Group Supports

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ● **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
This service provides employment services and training activities to support successful transition to individualized integrated employment or self-employment, or to supplement such employment and/or self-employment when it is only part-time. The maximum size of a small group is six (6) persons in order to maximize the likelihood of interaction between Supported Employment-Small Group participants and non-disabled persons also present in the setting and reduce stigma associated with congregation of individuals with disabilities.

Services typically include employment in integrated business, industry and community settings. Examples include mobile crews and small enclaves participating in integrated community employment that results in acquisition of knowledge, skills and experiences that facilitate transition to individualized integrated employment or self-employment, or that supplement such employment or self-employment when it is only part-time.
• In the enclave model, a small group of people with disabilities (no more than 6 persons with disabilities and ideally also including workers without disabilities) is trained and supervised to work among employees who are not disabled at the host company's work site. Persons in the enclave may work as a team at a single work area or may work in multiple areas throughout the company. The Supported Employment—Small Group provider is responsible for training, supervision, and support of participants. The provider is expected to conduct this service in integrated business, industry or community settings that meet all HCBS setting standards and do not isolate participants from others in the setting who do not have disabilities. The experience should allow opportunities for routine interactions with others without disabilities in the setting and involvement from supervisors and co-workers without disabilities (not paid to deliver this service) in the supervision and support of individuals receiving this service.
• In the mobile work crew model, a small crew of workers (including no more than 6 persons with disabilities and ideally also including workers without disabilities) work as a distinct unit and operate as a self-contained business that generates employment for their crew members by selling a service. The crew typically works at several locations within the community. The Supported Employment—Small Group provider is responsible for training, supervision, and support of participants. The provider is expected to conduct this service in integrated business, industry or community settings that meet all HCBS setting standards and do not isolate participants from others who do not have disabilities. The experience should allow opportunities for routine interactions with people without disabilities (including fellow crew members, customers, etc.) in the course of performing services.

For individuals not already working in individualized integrated employment or self-employment, this service involves small group career planning and exploration, small group Discovery classes/activities, and other educational opportunities related to working successfully in individualized integrated employment or self-employment (e.g. financial literacy; basic work incentives overview). Such activities must be conducted in appropriate non-disability-specific settings (e.g. Job Centers, businesses, post-secondary education campuses, libraries, etc.) All settings must meet all HCBS setting standards and must not isolate participants from others who do not have disabilities.

Supported Employment—Small Group services shall be provided in a way that presumes all participants are capable of working in individualized integrated employment and/or self-employment. Participants in this service who are not yet working in individualized integrated employment or self-employment shall be encouraged, on an ongoing basis, to explore and develop their interests, strengths, and abilities relating to individualized integrated employment and/or self-employment. In order to reauthorize this service, the Person Centered Plan (PCP) must document that such opportunities are being provided through this service, to the individual, on an on-going basis. The PCP shall also document and address any barriers to the individual transitioning to individualized integrated employment or self-employment if the person is not already participating in individualized integrated employment or self-employment.

Any individual using this service to supplement part-time individualized integrated employment or self-employment shall be offered assistance to increase hours in individualized integrated employment and/or self-employment as an alternative to continuing this service.

The expected outcome of this service is the acquisition of knowledge, skills and experiences that facilitate career development and transition to individualized integrated employment or self-employment, or that supplement such employment and/or self-employment when it is only part-time. The individualized integrated employment or self-employment shall be consistent with the individual's personal and career goals.

Paid work under Supported Employment—Small Group shall be compensated at minimum wage or higher. Supported Employment – Small Group Support arrangements established prior to July 1, 2017, may pay participants at subminimum wage as long as the employer is certified for subminimum wage by the Department of Labor. Arrangements established on or after July 1, 2017 must pay individuals at or above minimum wage.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Supported Employment—Small Group does not include prevocational services, including employment or training provided in facility based or sheltered work settings, nor does it include supports for volunteering. Supported Employment—Small Group services cannot be provided in settings that are not regular business, industry and community settings that also meet the HCBS settings rule standards.

Transportation of the individual to and from these services is included in the rates paid for these services, if needed by individuals participating in these services; however, face-to-face time spent transporting an individual to and from these services is not considered billable time. Transportation during the provision of these services is also included in the rates paid for these services.

The Supported Employment—Small Group provider shall be responsible for any personal assistance needs during the hours that Supported Employment-Small Group services are provided; however, the personal assistance services may not comprise the entirety of the Supported Employment—Small Group service.

This waiver will not cover Supported Employment-Small Group services which are otherwise timely available to the individual under section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.). Documentation is maintained that the specific type(s) of Supported Employment-Small Group services being provided is not immediately available, or available without undue delay, to the individual under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

This service may be combined with services being provided to the individual under section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.), so long as this service is not duplicative of what is being provided to the individual under section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.).

An individual's person-centered support plan may include more than one non-residential habilitation service (Supported Employment-Individual, Supported Employment-Small Group, Community Day Services);

however, they may not be billed for during the same period of time (e.g., the same 15 minute or hour unit of time).

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
o Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment;
o Payments that are passed through to users of supported employment services; or
o Payments for training that is not directly related to an individual's supported employment program.

The annual rate is spread over a State fiscal year maximum of 1,100 hours for any combination of day programs. Payment during any month is limited to a maximum of 115 hours for any combination of day programs.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community-Based Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Supported Employment – Small Group Supports

Provider Category:
Agency
Provider Type:
Community-Based Agencies
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
• Job Coach Qualifications:
o High School Diploma or GED
o Pass registry and background check(s) required by the OA
o Complete all staff training requirements as specified in OA guidelines
o Successfully complete Job Coach certification within 6 months of hire
Successfully complete TRN "Job Coaching and Consulting on-demand" on-line competency-based training: http://trn-store.com/catalog/job-coaching-and-consulting
Complete 40 hours of job shadowing with Supported Employment – Individual Employment Supports in at least three different employment situations

o Valid driver's license if providing service in area where this is necessary.
o Automobile liability insurance if DSP will be transporting waiver participants in his/her own vehicle.

Verification of Provider Qualifications

Entity Responsible for Verification:
Waiver Operating Agency (OA)

Frequency of Verification:
The OA verifies upon enrollment and conducts an annual review of contract continuation.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Temporary Assistance

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ● **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope)*:
Temporary Assistance services are provided on an emergency temporary basis because of the absence or incapacity of the persons who normally provide unpaid care. Absence or incapacity of the primary caregiver(s) must be due to a temporary cause, such as hospitalization, illness, injury, or other emergency situation. Temporary Assistance services are not available for caregiver absences for vacations, educational or employment-related reasons, or other non-emergency reasons.

Temporary Assistance services include:

• Teaching adaptive skills to assist the participant to reach personal goals;
• Personal assistance in activities of daily living;
• Services provided on a short-term basis because of the absence, incapacity or need for relief of those persons who normally provide care (typically referred to as respite).
Supports are typically provided in such areas as eating, bathing, dressing, personal hygiene, community integration, meal preparation (excluding the cost of the meals), transportation and other activities of daily living. Supports may be provided to assist the participant to perform such tasks as light housework, laundry, grocery shopping, using the telephone, and medication management, which are essential to the health and welfare of the participant, rather than for the participant's family. Supports may be provided to develop skills in money management or skills necessary to self-advocate, exercise civil rights and exercise control and responsibility over other support services. Such assistance also may include the supervision of participants as provided in the service plan.

Temporary Assistance may function as an extension of behavioral and therapy services. Extension of services means activities by the Temporary Assistance/Personal Support worker that assists the participant to implement a behavioral, occupational therapy, physical therapy, or speech therapy plan to the extent permitted by state law and as prescribed in the support plan. Implementation activities include assistance with exercise routines, range of motion, reading the therapist's directions, helping the participant remember and follow the steps of the plan or hands-on assistance. It does not include the actual service the professional therapist provides.

Temporary Assistance is not intended to include professional services, home cleaning services, or other community services used by the general public. Some professional services are covered elsewhere under the home-based supports option.

Temporary Asssitance may be provided in the participant's home and may include supports necessary to participate in other community activities outside the home.

The need for Temporary Assistance and the scope of the needed services must be documented in the person centered plan.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The rate, amount and frequency for this service must be specified in the Service Agreement(s) and in the Person Centered Plan (PCP).

This service is not included in the participant's monthly home-based supports cost maximum.

Temporary Assistance services up to an additional $4000 per episode may be authorized for family emergencies subject to prior approval by the Operating Agency. Temporary Assistance services may not exceed $2,000 in any single month and may not be authorized for more than two consecutive months or 60 consecutive days. The limits were established through input from an external advisory committee of consumers, family members, providers, and other advocates and are based on their opinions of individuals' and families' needs.

This service is subject to prior approval by the Operating Agency. The Independent Service Coordination (ISC) agency will submit a written request for prior authorization for Temporary Assistance services on behalf of the individual. The OA will respond in writing to the request within 30 calendar days. However, when an unplanned need occurs, Temporary Assistance services may begin upon receipt of verbal approval from the OA. The OA will provide verbal approval ASAP but no later than 24 hours of receipt of request, in those cases of unplanned need. Subsequent written approval is issued to the participant and ISSA by the OA.

For young adults between age 18 and 22 who attend secondary education, Temporary Assistance services may not be delivered during the typical school day relative to the age of the participant or during times when educational services are being provided.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Temporary Assistance/Personal Support Worker
Agency	Community-Based Agencies and Special Recreation Associations

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Temporary Assistance

Provider Category:
Individual

Provider Type:
Temporary Assistance/Personal Support Worker

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Aged 18 or older and is deemed by the participant or guardian, if one has been appointed, to be qualified and competent to meet the participant's needs and carry out responsibilities assigned via the person centered plan.

Temporary Assistance workers hired on or after July 1, 2007, must pass required background checks including criminal background and Health Care Worker Registry checks prior to employment and annually thereafter.

Verification of Provider Qualifications

Entity Responsible for Verification:
Financial Management Service (FMS) entities and Waiver Operating Agency (OA)

Frequency of Verification:
Financial Management Service entity verifies upon enrollment and the Waiver Operating Agency (OA) conducts annual compliance review of a representative sample of participants.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Temporary Assistance

Provider Category:
Agency

Provider Type:
Community-Based Agencies and Special Recreation Associations

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:

The provider must be under contract with the Operating Agency. Per these contracts, employees must complete DHS-approved direct support personnel training program and pass competency-based training assessments (40 hours of classroom and 80 hours of on-the-job training) and be certified as direct support personnel (DSP).

All employees must pass required background checks including criminal background and Health Care Worker Registry checks prior to employment and annually thereafter.

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver Operating Agency (OA)

Frequency of Verification:

The Waiver Operating Agency (OA) verifies upon enrollment and conducts an annual review of contract continuation.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Training and Counseling Services for Unpaid Caregivers

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Training and Counseling services are provided to individuals who provide unpaid support, training, companionship or supervision to participants. For purposes of this service, individual is defined as any person, family member, neighbor, friend, companion, or co-worker who provides uncompensated care, training, guidance, companionship or support to a Waiver participant. Training includes instruction about treatment regimens and other services included in the support plan, use of equipment specified in the person centered plan, and includes updates as necessary to safely maintain the participant at home. All training for individuals who provide unpaid support to the participant must be included in the participants Person Centered Plan.

Training furnished to individuals who provide uncompensated care and support to the participant must be directly related to their role in supporting the participant in areas specified in the person centered plan. Counseling must be aimed at assisting the unpaid caregiver in understanding and meeting the needs of the participant.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
This service will not be duplicative of other services in the Waiver. For example, the Adaptive Equipment/Assistive Technology service includes training for family members in the use and/or maintenance of the device, therefore, Training and Counseling could not cover this type of training.

This service may not be provided in order to train paid caregivers or school personnel.

For participants who choose participant-directed supports, this service is included in the participant's monthly cost limit. See Appendix C-4.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Specialized Training providers
Individual	Licensed counselors

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Training and Counseling Services for Unpaid Caregivers

Provider Category:
Agency
Provider Type:
Specialized Training providers
Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Training programs, workshops or events deemed qualified by the participant/guardian (if one has been appointed) and approved by the ISC. Examples include CPR instruction, first aid, and programs on disability-specific topics such as epilepsy, autism, etc.

Verification of Provider Qualifications

Entity Responsible for Verification:
Waiver Operating Agency (OA)

Frequency of Verification:
Upon enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Training and Counseling Services for Unpaid Caregivers

Provider Category:
Individual

Provider Type:
Licensed counselors

Provider Qualifications

License *(specify)*:
225 ILCS 15/1 et. seq.
68 Ill. Adm. Code 1400
225 ILCS 20/1 et seq.
68 Ill. Adm. Code 1470
225 ILCS 55/1 et seq.
68 Ill. Adm. Code 1283
225 ILCS 107/1 et seq.
68 Ill. Adm. Code 1375
225 ILCS 20/1 et seq.
68 Ill Adm. Code 1470
225 ILCS 107/1 et seq.
68 Ill. Adm. Code 1375

Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:
Waiver Operating Agency (OA)

Frequency of Verification:
Upon enrollment by the OA. The MA conducts monthly check for continuation of licensure.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Vehicle Modification

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Vehicle Modifications are adaptations or alterations to an automobile or van that is the participant's primary means of transportation in order to accommodate the special needs of the participant. Vehicle adaptations are specified by the person centered plan as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant. The vehicle that is adapted must be owned by the participant, a family member with whom the participant lives or has consistent and on-going contact, or a non-relative who provides primary long-term support to the participant and is not a paid provider of such services.

The upkeep and maintenance of the modification is included in this service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service will not be duplicative of other services in the waiver. For example, vehicle modifications are within the transportation component of Residential Habilitation and Developmental Training services.

The following are specifically excluded:

1. Adaptations or improvements to the vehicle that are of general utility, and are not of direct remedial benefit to the participant;
2. Purchase or lease of a vehicle; and
3. Regularly scheduled upkeep and maintenance of a vehicle.

For participants who choose participant-directed supports, this service is not included in the participant's monthly cost limit. There is a $15,000 maximum per participant per five-year period for any combination of adaptive equipment, assistive technology, home modifications, and vehicle modifications. See Appendix C-4. This service requires prior approval by the Operating Agency.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Equipment Vendor and Installer

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Vehicle Modification

Provider Category:
Agency
Provider Type:
Equipment Vendor and Installer
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Enrolled vendor approved by the participant or guardian, if one has been appointed.
Verification of Provider Qualifications
Entity Responsible for Verification:
Waiver Operating Agency (OA)
Frequency of Verification:
Upon enrollment

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. **Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ● **Applicable** - Case management is furnished as a distinct activity to waiver participants.
  Check each that applies:
  - ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
  - ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
  - ☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
  - ☑ **As an administrative activity.** *Complete item C-1-c.*

c. **Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Case Management services are provided by Qualified Intellectual Disability Professional (QIDP) staff working for Independent Service Coordination (ISC) agencies under contract with the Operating Agency.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. **Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ● **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Criminal background checks with the Illinois State Police are required for staff hired by agencies providing Residential Habilitation services, Site-Based Developmental Supports, Adult Day Care, Supported Employment, Information and Assistance in Support of Participant Direction, Personal Support, or Individual Service and Support Advocacy. These agencies may not knowingly hire or retain any person in a full-time, part-time or contractual direct service position if that person has been convicted of committing or attempting to commit one or more of the offenses in the Illinois Health Care Worker Background Check Act (225 ILCS 64/25), unless the person obtains a waiver of the conviction.

For individual providers hired as common law employees on or after July 1, 2007, the Financial Management Service (FMS) entity/entities under contract with the OA, is required to obtain criminal background checks and not enroll or retain independent personal support workers (common law employees or domestic employees) if the person has been convicted as described above. The FMS vendor obtains the criminal background check on behalf of all participants who hire independent personal support workers. The results are kept on file with the FMS entity.

When determining whether to grant a waiver for employees or potential employees found on the CANTS registry, the OA reviews applications for a waiver based on individual circumstances. The factors considered include, but are not limited to, the following:
-Circumstances surrounding the event,
-Work history of the employee requesting the waiver,
-Recommendation of employer or potential employer,
-The provider's quality review and licensure survey results,
-The amount of supervision the employee will receive,
-The length of time since the incident,
-The age of the employee at the time of the incident, and
-The results of a cross check in the Adult Registry.

Further, any waiver would be granted for the employee or potential employee while working in a specific job title for the provider involved in the waiver request only. Should the employee change jobs or providers, the decision whether to grant a waiver would be considered again.

Annually the OA reviews providers and FMS entities (for domestic employees) through a representative sample of participants for compliance with this requirement. These reviews consist of onsite documentation reviews of the results of the background checks maintained by the provider. As non-compliance with mandatory investigations is identified, corrective action plans, approved by the OA, are required to address findings.

The scope of the required investigations include an Illinois State Police criminal background check and a check of the Illinois Sex Offender Registry.

b. **Abuse Registry Screening.** Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- ○ **No. The State does not conduct abuse registry screening.**
- ◉ **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

By statute, the Illinois Department of Public Health maintains an adult abuse and neglect registry. The registry is called the Healthcare Worker Registry (formerly known as the Nurse Aide Registry). The state law governing the Health Care Worker's Registry is the Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30).

Waiver providers are required by the OA to complete registry checks on all employees. Employees cannot be hired if they fail the registry checks. The results of the registry checks are documented by the provider.

Abuse/neglect screenings are required for all domestic employees hired on or after July 1, 2007, who provide Personal Support or Temporary Assistance services. Such individuals may not be employed in any capacity until the employer has checked the individual against the Ill. Department of Public Health, Health Care Worker Registry and the Ill. Department of Children and Family Services Registry. The FMS entities conduct the registry checks for all personal support workers employed directly by the participant or their representative.

Abuse/Neglect screenings are required for all individuals providing Residential Habilitation, Developmental Training, Supported Employment, Information and Assistance in Support of Participant Direction, Personal Support or Independent Service Coordination (ISC) services. Such individuals may not be employed in any capacity until the employer has checked the individual against:
• The Illinois Department of Public Health (IDPH) Health Care Worker Registry, and
• The Illinois Department of Children and Family Services (DCFS) State Central Register (Children's Abuse and Neglect Tracking System - CANTS).

If either database reports substantiated or indicated findings of physical or sexual abuse or egregious neglect, the person may not be employed.

When determining whether to grant a waiver for employees or potential employees found on the CANTS registry, the OA reviews applications for a waiver based on individual circumstances. The factors considered include, but are not limited to, the following:
-Circumstances surrounding the event,
-Work history of the employee requesting the waiver,
-Recommendation of employer or potential employer,
-The provider's quality review and licensure survey results,
-The length of time since the incident,

-The age of the employee at the time of the incident, and
-The results of a cross check in the Adult Registry.

Further, any waiver would be granted for the employee or potential employee while working for the provider involved in the waiver request only. Should the employee change providers, the decision whether to grant a waiver would be considered again.

The OA and the MA, through a representative sample, review providers and FMS entities for compliance with this requirement.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. **Services in Facilities Subject to §1616(e) of the Social Security Act.** *Select one:*

- (●) **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- ( ) **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. **Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- (●) **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ( ) **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

- [ ] **Self-directed**
- [ ] **Agency-operated**

e. **Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

The State does not make payment to relatives/legal guardians for furnishing waiver services.

The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.

Specify the controls that are employed to ensure that payments are made only for services rendered.

Parents, other relatives, and legal guardians may provide Personal Support, Temporary Assistance, and Non-medical Transportation services. The relative or legal guardian must meet the same provider qualification criteria, and pass the required background checks, that are applicable to any provider rendering the same services.

Parents, other relatives, and legal guardians may not provide host family services (i.e., foster care and other shared living arrangements) under Residential Habilitation services. This prohibition is specified in Illinois Administrative Code, available upon request from either the Medicaid or Operating Agency.

Legally responsible relatives (i.e., spouses) may not be paid to provide waiver services, as specified in Appendix C-2(d) above.

The person centered plan governs the services to be provided, including those provided by relatives and legal guardians. For participants who exercise employer authority, the Financial Management Service (FMS) entity receives time sheets detailing the date and time of services delivered. The FMS entity conducts routine quality assurance activities.

The Case Manager, also known as the ISC, plays a key role in monitoring the implementation of the person centered plan and reporting any non-compliant issues or problems to the OA if direct interventions by the ISC do not work.

The OA through it's representative sample, reviews Personal Support, Temporary Assistance and Non-Medical Transportation, regardless of the provider relationship.

Payment arrangements to relatives and legal representatives may be reviewed and denied by the OA. Decisions to deny by the OA are subject to waiver appeal rights.

Other policy.

Specify:

f. **Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

As part of the participant-centered planning process, participants in the Developmental Disabilities Adult Waiver and their guardian, if one has been appointed, are responsible for selecting needed services and qualified service providers. The ISC helps to facilitate this process. If a qualified provider is selected who is not currently enrolled, the OA, in conjunction with the MA, enrolls the new provider. For participants or their guardian (as applicable), who choose to exercise employer authority, the Financial Management Service (FMS) entity assists with new provider enrollment.

Information regarding provider qualifications and program guidelines is continuously available on the Operating Agency's website at http://www.dhs.state.il.us/page.aspx?item=47336. This website lists all types of providers within the developmental disabilities services system, briefly describes what each does, lists requirements and qualifications, links those interested to regulatory documents and forms, and provides contact information.

Potential providers must review the regulatory documents linked to the website. They must also complete the required forms for their provider type and submit them to the contact person listed.

Each provider must complete a Medicaid Provider Enrollment agreement, which is a three-way agreement among the provider, OA, and MA.

The State does not impose barriers to the free choice of willing and qualified providers.

The Operating Agency (OA) reviews and approves service providers for participation in the Adults with Developmental Disabilities Waiver based on the provider qualifications as specified in the Waiver.

The State Medicaid Agency enrolls all willing and qualified providers that are chosen by participants or guardian, if one is appointed, in the Adults with Developmental Disabilities Waiver. The MA maintains the waiver provider database.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Qualified Providers**

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. **Sub-Assurances:**

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
C1 Number and percent of licensed or certified providers who meet initial licensure/certification standards prior to furnishing waiver services. N: Number of newly enrolled licensed or certified providers who meet initial standards. D: Total number of newly enrolled licensed or certified providers.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:
OA provider licensure and certification database

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☐ State Medicaid Agency	☐ Weekly	☑ 100% Review
☑ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify:	☑ Annually	☐ Stratified Describe Group:
	☑ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☑ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify:	☑ Annually
	☑ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

C2 Number and percent of licensed or certified providers who continue to meet licensure/certification standards on an ongoing basis. N: Number of licensed or certified providers who continue to meet standards on an ongoing basis. D: Total number of enrolled licensed/certified providers.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:
MA reviews all licensed clinicians. OA and MA merge and compare data for analysis and reporting purposes.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
C3 The number and percent of non-licensed/non-certified providers reviewed, by provider type, who meet initial waiver provider qualifications. N: Number of non-licensed/non-certified providers who met initial qualifications. D: Total number of newly enrolled non-licensed/non-certified providers.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:
OA database on provider qualifications

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:

	☑ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☑ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify:	☑ Annually
	☑ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:
C4 The number and percent of non-licensed/non-certified providers reviewed, by provider type, who continue to meet waiver provider qualifications. N: Number of non-licensed/non-certified providers who continue to meet qualifications. D: Total number of non-licensed/non-certified providers.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:
OA database on provider qualifications

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☑ State Medicaid Agency	☐ Weekly	☑ 100% Review
☑ Operating Agency	☐ Monthly	☐ Less than 100% Review

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
C6 Number and percent of independent personal support providers (domestic employees) screened by FMS vendors (on behalf of waiver participants who self-direct and exercise employer authority) who passed initial background and registry checks and thus were deemed eligible for hire. N: Number of domestic employees who passed initial checks. D: Total number of domestic employees hired.

Data Source (Select one):
Other

If 'Other' is selected, specify:
FMS vendor reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
C5 Number and percent of providers reviewed, by provider type, who meet waiver provider training requirements. N: Number of providers who met training requirements. D: Total number of providers subject to training requirements.

Data Source (Select one):
Training verification records
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
As required under the direction of the AA CAP, oversight will include the MA working with the contracted QIO to monitor the service planning process and compliance and ensure that performance measures are being followed and met. In addition, the MA will work with the OA to ensure that the service plans comply with Person Centered Planning. Other measures, if needed, will be addressed via the AA CAP and discussed monthly with CMS.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The OA is responsible for individual remediation which upon discovery includes: imposing sanctions, as appropriate, terminating provider agreements, and prohibition of new placements/enrollments.

The OA is responsible for individual remediation which includes: upon discovery, completion of required checks by FMS entity and if eligible for hire, no further action. If not eligible for hire, notification to participant and provider termination of employment. Depending on the number of findings, a POC from the FMS entity may be required. If repeat findings and responsiveness to POC warrant further action, contract penalties will be imposed up to and including contract termination.

The OA is responsible for individual remediation which includes, upon discovery, notification to provider out of compliance with training requirements. If provider comes into compliance, no further action is taken. If provider does not come into compliance, termination of waiver agreement with notification to affected participants. In some cases, a POC may be required.

The OA may impose sanctions on providers which fails to comply with conditions stipulated in the provider contract. Sanctions include, but are not limited to, payment suspension, loss of payment, and enrollment

limitations, or actions up to and including contract termination.

The OA provides quarterly reports of these remediation activities to the MA. Staff of the MA and OA review the reports which are documented in the Waiver Quality Management Committee (QMC) meeting summaries.

ii. **Remediation Data Aggregation**
Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. **Timelines**
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**
○ **Yes**
Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services
C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services
C-4: Additional Limits on Amount of Waiver Services

a. **Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

○ **Not applicable-** The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
◉ **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c)

how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☑ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

In addition to the information contained in the OA's Waiver Manual, each participant receives an initial award letter that contains service limits.

The service limits are discussed verbally during the annual person centered planning process. The ISC reviews service limits with the participant and guardian, if applicable. The written person centered plan is signed by the participant, or his or her guardian (if one has been appointed), and the ISC.Providers responsible for the plan's implementation must also sign the plan.

Maximum for Modifications and Tangible Items
There is a $15,000 maximum per participant per five-year period for any combination of Adaptive Equipment/Assistive Technology, and Home and Vehicle Modifications. Within the five-year maximum, there is also a $5,000 maximum per address for permanent home modifications for rented homes. Participants are informed of their right to request a fair hearing, in the event any requests are denied. Participants are notified of the limits in the OA's Waiver manual.

Any combination of Community Day Services and Supported Employment services cannot exceed 1100 hours per year. This limit was established through a review of historical expenditures and is based on hours of operation for day programs established in Illinois Administrative Code, Title 59, Chapter 1, Part 119.

Behavior Intervention and Treatment services cannot exceed 104 hours per year. These limits were established through a review of historical expenditures.

Any combination of Individual Counseling, Group Counseling, Individual Therapy, and Group Therapy cannot exceed a maximum of 60 hours per fiscal year. These limits were established through a review of historical expenditures.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☑ **Other Type of Limit.** The State employs another type of limit.
Describe the limit and furnish the information specified above.

The annual home-based supports budget limits are based on the Illinois Home-Based Support Services Law for Mentally Disabled Adults [405 ILCS 80]. The limits are based on Social Security benefit levels and are adjusted each January when Social Security benefits are adjusted for cost of living increases. These statutory budget limits were set through a public legislative process that included opportunities for public comment by advocates and individuals with mental disabilities and their families.

The total amount of Waiver services provided in any month is determined by the person centered plan of the participant within the program maximums. The annual person centered plan is developed by the ISC and is based on assessments of the participant's needs.

Written notices of changes to limits are sent to all participants/guardians (as applicable), Financial Management Service (FMS) entities, and Independent Service Coordination (ISC) agencies by the OA.

The monthly home-based support services budget limits, currently $2,205 for calendar year 2017 (or $1,470 if between the ages of 18 and 22 and still attending school), together with natural supports, general community resources, school-based services (for young adult participants still attending school), and Medicaid State Plan services are sufficient to meet the participant's needs. If the health and welfare of the participant cannot be assured on a long-term basis within the cost limit of home-based supports in combination wiht other natural supports and community resources, the participant will be considered for other service options within the Waiver, including residential service supports that are not participant-directed and some that are provided 24 hours a day, seven days a week. Pariticipants are notified of the opportunity to request a fairing hearing if enrollment is denied.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

The Operating Agency (DHS DDD) conducts annual site visits to each of the Residential Habilitation(residential) and Developmental Training (non-residential) providers in the waiver. Site visits are unannounced and comprehensive in nature. Results are discussed with the provider prior to exit and, depending on the nature of the findings, a plan of correction is required by the OA. Results from the collective site visits are reported on a quarterly basis to the Waiver Quality Management Committee which includes key staff from the MA (Dept. of Healthcare and Family Services).

In addition to annual monitoring by the OA, the OA also contracts with Independent Service Coordination (ISC) agencies who visit each child on a quarterly basis to ensure that the person centered plan is being implemented and that the ongoing health, welfare and safety of the waiver participants are assured.

These group home settings were included as part of the recent survey conducted by an outside contractor (Univ. of Illinois at Springfield) to determine compliance with the new HCB setting requirements. The survey results are part of the Waiver Transition Plan submitted to CMS. Additional activities planned to verify the survey results and full compliance are outlined in the Waiver Transition Plan.
Also, key to our Statewide Transition are planned site visits to further address compliance that may be issues in Illinois statutes, rules, Medicaid authority and Operating entities policies, contracts, procedures, forms and the setting's internal policies and practices, all to ensure the highest level of compliance with rules relating to settings. The Illinois Transition Plan has timeline for all of these deliverables.